Non-Traditional Medicaid Plan

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1. SERVICES

The Non-Traditional Medicaid Plan imposes additional limitations and/or restrictions, under a waiver of federal regulations, on benefits and services covered by the Medicaid State Plan.

Providers of Non-Traditional Medicaid services are responsible for compliance with Medicaid policy and requirements as set forth in the Medicaid Provider Agreement, the Utah Medicaid Provider Manual, Medicaid Information Bulletins, and this Section for Non-Traditional Medicaid Services. Compliance includes all requirements of SECTION 1 of the Utah Medicaid Provider Manual; SECTIONS 2, 3, 4, and/or 5 as appropriate for the type of service; and any special attachments to the specific provider manual.

This section sets ADDITIONAL limitations for each type of service covered under the Non-Traditional Medicaid plan.

Verification

Qualified persons receive a blue NON-Traditional Medicaid Plan Identification Card.

1 - 1 Authority

This plan is authorized by a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services and allowed under 42 CFR4.35.1115, 2000-edition. This rule is authorized by Title 26, Chapter 18, Utah Code Annotated.

1 - 2 Definitions

- "Code of Federal Regulation" (CFR) means the publication by the Office of the Federal Register, specifically titled 42, used to govern the administration of the Medicaid program.

- "Client" means a person the Division or its duly constituted agent has determined to be eligible for assistance under the Medicaid program.

- "Division" means the Division of Medicaid and Health Financing within the Department of Health.

- "Emergency" means the sudden onset of a medical condition, traumatic injury or illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

  a) placing the client's health in serious jeopardy;
  b) serious impairment of bodily functions;
  c) serious dysfunction of any bodily organ or part; or
  d) death.

- "Emergency Department Service" means service provided in a designated acute care general hospital emergency department.

- "Emergency Service" means:
  1. Attention provided within 24 hours of the onset of symptoms or within 24 hours of making a diagnosis;

2. A condition that requires acute care, and is not chronic; It is reimbursed only until the condition is stabilized sufficiently that the patient can leave the hospital emergency department; and
3. It is reimbursed only until the condition is stabilized sufficiently that the patient can leave the hospital emergency department; and
4. It is not related to an organ transplant procedure,

- "Non-Traditional Medicaid Plan" means that plan developed under authority of a federal waiver which offers a reduced scope of service for a select group of Medicaid eligible individuals.

- "Outpatient Hospital Service" means medically necessary, diagnostic, therapeutic, preventive or palliative care provided for less than 24 hours in outpatient departments located in or physically connected to an acute care general hospital.

- "Provider" means any person, individual, corporation, institution or organization, qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

1 - 3 Co-payments

Co-payment and co-insurance apply to clients covered by the Non-Traditional Medicaid Plan. Clients are required to make a co-payment for the types of services listed below. The provider is responsible to collect the co-pay at the time of service or bill the client. The co-payment shall be collected even if the client has other third party coverage. **An exception to this policy is that co-payments are not taken out for Medicare Crossover claims.**

Medicaid will automatically reduce the payments for each of these services by the indicated co-payment or coinsurance amounts at the time of reimbursement. The amount of the co-pay is described on the attached Benefit Chart for Non-Traditional Medicaid Plan.

- Hospital inpatient and non-emergency use of Emergency Department
- Outpatient hospital services, including free standing surgical center services
- Office visits for physician services, except preventive services and immunizations
- Vision care over $30 a year
- Pharmacy Services
- Physical Therapy
- Occupational Therapy

Co-pay Maximum Per Client

The maximum out of pocket expense is $500 per calendar year per enrollee.

2 SCOPE OF SERVICE

As stated in Chapter 1, providers are responsible to follow general Medicaid policy and requirements set forth in published manuals for specific types of service, including any special attachments to that Manual. The Scope of Service outlined in the following chapters addresses the additional specific services and limitations which apply to this Non-Traditional Medicaid Plan.

GENERAL EXCLUSIONS

- Services which fail to meet existing standards of professional practice, which are currently unacceptable, or which are investigational or experimental in nature.
- Services primarily for convenience, contentment, personal, or other non-therapeutic purposes.
- Services which are not reasonable and necessary for the patient's medical care.
- Charges for services which the insured is not, in the absence of coverage, legally obligated to pay.
- Shipping, handling, or finance charges. Excluded Codes: 99000 – 99002
- Services or medical care rendered by an immediate family member.
- Services received as a result of an industrial accident or illness, any portion of which, is payable under workmen's compensation or employer's liability laws.
- Services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
- Expenses in connection with broken appointments (scheduled and not kept).
- Completion or submission of insurance forms. Excluded code: 99080.

2 - 1 Hospital Services

Hospital services encompass medical, surgical, or level of care needs which require the availability of specialized diagnostic and therapeutic services and close medical supervision of care and treatment directed toward improvement, maintenance, or protection of health or lessening of illness, disability or pain.

Services are based on physician orders. Coverage of these services includes use of hospital facilities, equipment and supplies; the technical portion of clinical laboratory and radiology services; nursing; medical social services and therapy services. **Revenue Codes** and **ICD.9.CM diagnosis/procedure codes are** the main means of documentation for hospital services

1. Covered Services for Hospitals

a. Medicaid documents which support policy for hospital services will be incorporated to implement this plan. The documents are:

(1) The Medicaid UB-04 Revenue Code List (See the UB-04 manual - Medicaid Section).

(2) The Hospital Surgical Procedures List is specific to hospitals and is included as a special attachment in the Utah Medicaid Provider Manual for Hospital Services. The procedures on

this list are those with federal requirements which must be upheld, along with other procedures requiring careful monitoring for payment to be made. The listed procedures have the associated ICD.9.CM Diagnosis codes, the associated CPT code for physician use, and the criteria specific to review of the procedures requiring prior authorization. Adherence to the requirements of this list is essential to payment for hospitals.

(3) The Medical and Surgical Procedures List is a comprehensive list of codes and services and is included as a special attachment in the Utah Medicaid Provider Manual for Physician Services. This list is taken from the Physician's Current Procedural Terminology Manual, and it can serve as a guide to covered services as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic or not reasonable or medically necessary. Nonspecific or unlisted codes are included and require physician review because of the potential for use to cover otherwise non-covered services. Additional non-covered services in the Non-Traditional Medicaid Plan are listed in "NTM - CPT Code List."

The list also identifies federally controlled hysterectomy, sterilization and abortion procedures that have strict requirements related to payment for both physician and hospital. The list also identifies transplant procedures, and those procedures which require prior authorization based on specific coverage criteria.

b. Diagnostic services performed by the admitting hospital or by an entity wholly owned or operated by the hospital within three days prior to the date of admission to the hospital are deemed to be inpatient services and are covered under the DRG.

c. Medical supplies, appliances, and equipment which are medically necessary and required for the care and treatment of a patient during the inpatient stay are covered Medicaid services under the DRG providing they meet established standards and limits identified in policy.

d. Drugs and biologicals appropriate for inpatient care and approved by the federal Food and Drug Administration are covered based on medical need and physician order. The drugs must be given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug.

e. Emergency Department Services approved for coverage are found on the Diagnoses for Emergency Department Reimbursement List and are included as a special attachment in the Utah Medicaid Provider Manual for Hospital Services. Any code other than those listed would be a non-covered service resulting in decreased payment. The diagnoses in the Authorized Emergency Department list are ICD.9.CM codes.

2. Limitation for Hospitals

a. Hospital services current coverage/non-coverage is documented on the Revenue Code List (See the UB-04 Manual - Medicaid Section).

b. The Hospital Surgical Procedures List identifies transplant procedures, sterilization, hysterectomy, and abortion procedures which have associated federal limitations; and a few other procedures which require monitoring for utilization. Associated with each procedure is the applicable ICD.9.CM diagnosis code, the related CPT Code (for physician use), and the designated, established criteria to be used by the Agency in prior authorization review and approval. All elements of the criteria must be met for payment to be made for any of these procedures.

c. The Medical and Surgical Procedures List contains procedures which are cosmetic, experimental or otherwise non-covered, or require prior authorization and the Medicaid limitations. This list identifies ICD.9.CM codes and criteria to be used for prior authorization review where applicable. In addition to the Medicaid Medical and Surgical Procedures List , see the "NTM - CPT Code List" in the Appendix.

d. Organ transplant procedures are limited to those for kidney, liver, cornea, bone marrow, stem cell, heart and lung.

e. Rehabilitation services are limited to those which meet criteria established by policy and reviewed through the prior authorization process.

f. Emergency Department services are limited to those identified by ICD.9.CM discharge diagnosis codes on the Medicaid list of Authorized Diagnoses for Emergency Department Reimbursement. Any code other than one of those listed is considered non-emergency use of the emergency room and subject to adjusted reimbursement.

g. Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification only. Any continuing therapy must be accessed under the outpatient substance abuse benefit.

h. Abortion procedures are limited to:

(1) those where the pregnancy is the result of an act of rape or incest, or

(2) a case with medical certification of necessity where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (Reference: 42 CFR 441.203)

i. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441 Subpart F which is adopted and incorporated by reference.

j. Cosmetic, reconstructive, or plastic surgery is limited to:

(1) correction of a congenital anomaly;
(2) restoration of body form following a recent accidental injury; or
(3) revision of severe disfiguring and extensive scars resulting from recent neoplastic surgery.

k. Laboratory services are limited to those tests identified by the Centers for Medicare and Medicaid Services for which the individual laboratory is CLIA certified. The CLIA list is included as a special attachment in the Utah Medicaid Provider Manual for Physician Services and also for Laboratory Services.

l. Observation or treatment room services are limited to 24 hours or less for cases where there is need for observation and evaluation to establish a diagnosis and/or the appropriateness of an inpatient admission. Use of observation status to submit ancillary charges associated with outpatient surgery, other outpatient diagnostic services, or other outpatient stays for any reason are excluded from reimbursement.

a. Exclusions for hospital service are currently non-covered on the recommended UB-04 Revenue Code List (See UB-04 Manual Medicaid Section).

b. Exclusions for diagnoses and surgeries are currently non-covered on the Medical and Surgical Procedures List.

2 - 2 End Stage Renal Disease - Dialysis

SECTION 2, Treatment of end stage renal failure by dialysis, is to be rendered by a Medicare-certified dialysis facility which has met the standards for operation and maintenance of End Stage Renal Disease facilities in order to provide safe and effective services.

1. Covered Services for End Stage Renal Disease - Dialysis

a. Covered Revenue Codes for the facility are: Revenue Codes 821, 831, 841, OR 851634 Epoetin Alpha (EPO) < 10,000 units 635 EPO > 10,000 units or more

b. Covered physician CPT Procedure Codes are: 90935, 90937, 90945, 90947

2 - 3 Physician Services

Physician services provide for the medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Physician services may be provided directly by the physician, osteopath, or by other professionals – licensed certified nurse practitioners, licensed certified nurse midwives, or physician assistants, authorized to serve the health care needs of the practice population through an approved scope of service under the physician's supervision.

1. Covered Services for Physician Services

a. Physician services include surgery and anesthesia.

b. The CPT Manual is the standard for defining and coding physician services. Not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable and medically necessary or cost effective. Nonspecific or unlisted services require physician review.

c. The Medicaid Medical and Surgical Procedures List, included as a special attachment in the Utah Medicaid Provider Manual for Physician Services, is implemented into this program. This list serves as a guide as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic, or not reasonable and necessary. The list applies to office service or to surgical procedures. In addition, there are some codes not covered in Non-Traditional Medicaid which are covered in Medicaid, see the "NTM - CPT Code List" in the Appendix.

d. The CPT office visit, Evaluation and Management codes (99201 - 99215) for either new or established patients, must be used appropriately.

e. Licensed, certified family or pediatric nurse practitioners are limited, under this Medicaid Scope of Service, to a cooperative ambulatory, office type, working relationship with a physician. When employed by the physician, the physician bills for the service.

f. Physician assistants work under the supervision of a physician to provide service to patients within the practice population.

g. Licensed, Certified Registered Nurse Midwife (CNM) practices with relative independence under the scope of licensure and in association with obstetricians/gynecologists or other physicians from whom they can seek consultation, or refer high risk patients when necessary. CNMs practice under a Medicaid Scope of Service, including unique codes, approved for their specialty.

2. Limitations for Physician Services

a. Some CPT procedures, e.g., experimental, ineffective, cosmetic, or those not cost effective, reasonable or medically necessary.

b. Nonspecific or unlisted codes to cover procedures not otherwise listed in the CPT Manual require Medicaid physician consultant review and approval.

c. Limitations on physician services and medical visit exclusions described in the Medicaid Medical and Surgical Procedures List and the "NTM - CPT Code List".

d. Office visit codes (E/M) and service codes (10060 - 69990) or (90780 - 99199) on the same date of service.

e. After-hours office visit codes cannot be used in a hospital setting, including emergency department, by private or staff physicians. They cannot be used for standby for surgery, delivery, or other similar circumstances, and they cannot be used when seeing a new patient. Billing for after-hours service in an established patient requires the service be provided outside of scheduled staff hours as described in the Medicaid manual.

f. Subsequent hospital care codes (99231 - 99233) shall not be billed following any surgical procedure. Surgical procedures are covered by a global fee.

g. Cognitive services are limited to one service per day by the same provider.

h. Office or hospital visits one day prior or the same day as a surgical procedure are considered part of the global surgical procedure and paid accordingly.

i. Substance abuse and dependency treatment is limited to specific provider groups with some service limitations.

j. Modifier 25 will not be recognized as a stand-alone entity to override the one service per day limitation.

k. Modifier 57 will not be recognized. A decision for surgery is an integral part of office visits covered before or immediately prior to the preoperative office visit that is part of the global fee.

l. Laboratory services provided by a physician in his office are limited to the approved kits, waived tests or those laboratory tests identified by CMS for which an individual physician is CLIA certified.

m. A specimen collection fee is limited only to venipuncture specimens drawn under the supervision of a physician to be sent outside of the office for processing. Any blood test obtained by heel or finger stick will post a mutually exclusive edit with 36415 – venipuncture. The following codes have been added as mutually exclusive to 36415: 82948–blood glucose, reagent strip, 85013–spun hematocrit, 85014–hematocrit, 85610–Prothrombin time, 83036–

glycated hemoglobin, and 86318 –immunoassay for infectious agent by reagent strip when submitted with the modifier QW.

n. Anesthesia services are limited to those provided directly to a patient in conjunction with authorized, covered surgical services. Monitored or standby service is not covered. Regional anesthesia provided by the surgeon who does not require monitoring such as code 01995 is included within the global surgical fee and is not separately reimbursable. When monitoring is required during regional or local anesthesia, services are payable to the anesthesiologist.

o. Abortion procedures are limited consistent with 42 CFR 441.203.

See Criteria # 17 of the Criteria for Medical and Surgical Procedures List, included as a special attachment in the Utah Medicaid Provider Manual for Physician Services.

p. Hysterectomy and sterilization procedures are limited to those which meet requirements of 42 CFR Subpart F. See Criteria # 10, or #14, or #15 of the Criteria for Medical and Surgical Procedures List. Occlusive device sterilization (i.e. Essure) is not covered.

q. Removal of benign or pre-malignant skin lesions are limited by Criteria #34 (Criteria for Medical and Surgical Procedures List).

r. Trigger Point Injections are limited by Criteria #33 (Criteria for Medical and Surgical Procedures List).

s. agnetic resonance imaging procedures are limited to coverage only for the brain, spinal cord, hip, thigh and abdomen.

t. Over-the-counter drugs and medications are limited to those on the list of covered OTC drugs established for this plan.

u. Vitamins are not covered.

v. Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs.

w. Additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration for additional reimbursement.

x. Medical services provided by ophthalmologists or optometrists are limited to codes 92002, 92004, 92012, 92014, 92020, 92083, 92135, 65210, 65220,65222, 67820, 68761, 68801, 95930, 99201- 99205, 99211-99215.

y. In order to comply with provisions of the Deficit Reduction Act of 2006, section 6002, billings for medications administered in the physician's office must include the National Drug Code (NDC) from the container from which the medication is obtained, and the number of units administered in addition to the "J" Code normally used. Billings for all drugs administered in the physician's office without the NDC information will be denied for payment beginning with the reporting deadline of January 1, 2007, specified in the DRA for single source drugs.

3. Non Covered Services for Physician Services

a. Anesthesia exclusions are supported by links to the procedures that are identified as non-covered or ineligible.

b. Medical visit exclusions are covered under limitations or as listed on the Medical and Surgical Procedures List and the "NTM - CPT Code List".

c. In addition to codes which are stated to be "NOT A BENEFIT," the hospital or physician services listed below are not covered.

(1) Office visits in conjunction with allergy injection. The excluded codes are: 95115 through 95134, 95144 through 95199

(2) Genetic counseling and testing, except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.

(3) Nutritional counseling or analysis. Excluded codes are 97802 through 97804.

(4) Vision therapy.

(5) Tobacco abuse counseling and therapy.

(6) Take-home medication from a provider's office.

(7) Rolfing or massage therapy. Excluded code is 97124.

(8) Care, treatment or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.

(9) Prolotherapy or chelation therapy.

(10) Office calls in conjunction with repetitive therapeutic injections.

(11) Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school. Excluded codes are: 97005, 97006, 97537, 97545, 99080.

(12) Special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's office.

(13) Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise programs.

(14) Treatment of routine foot care such as weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics and arch supports; palliative care of metatarsalgia or bunions, corns, warts, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease, such as diabetes. Excluded codes are: 11055 - 11057, 11719 - 11721, 97504, 97520, 97703.

(15) Services or complications incurred as an organ or tissue donor.

d. Excluded family planning services are listed below:

(1) Norplant: CPT Procedure Codes 11975, 11976, 11977

(2) Infertility studies and reversal of sterilization: ICD.9.CM Diagnosis Codes: Male - 606.0 - 606.96CPT Procedure Codes: 54240, 54250, 54900, 54901, 55200, 55300, 55400. ICD.9. CM Diagnosis Codes: Female - 256.0 - 256.9; 628.0 - 628.9CPT Procedure Codes: 58345, 58350, 58750, 58752, 58760, 58770

(3) Assisted Reproductive Technologies (ART's) (in-Vitro) ICD.9.CM Diagnosis Code: V26.1 and above infertility diagnosis codes. ICD.9.CM Procedure Codes: 66.1, 66.8, 69.92, 87.82, 87.83. CPT Procedure Codes are: 58321, 58322, 58323, 58970, 58974, 58976, 89250, 89251, 89252, 89253, 89254, 89255, 89256, 89257, 89258, 89259, 89260, 89261, 89264, 89321

(4) Genetic CounselingICD.9.CM Diagnosis Code: V26.3, V65.40, V25.09. CPT Procedure Codes for cytogenetic studies: 88230 - 88299

(5) Occlusive device sterilization (i.e. Essure)

e. Polysomnography studies are covered when CPAP titration is required for obstructive sleep apnea. Polysomnography (code 95810) is not covered in non-pregnant adults.
f. Spinal neurostimulator.
g. Both restrictive gastric bariatric surgery and gastric banding.

2 - 4 Laboratory and Radiology Services

Professional and technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

1. Covered Services for Laboratory and Radiology Services

70000 and 80000 series of CPT Procedure Codes.

2. Limitations for Laboratory and Radiology Services

a. Laboratory services are limited under federal CLIA regulations. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. The CLIA list is included as a special attachment in the Utah Medicaid Provider Manual for Physician Services and also for Laboratory Services.

b. Only CLIA-certified laboratories can complete certain tests and receive payment.

c. Some laboratory and radiology procedures are non-covered and listed on the Medicaid Medical and Surgical Procedures list and "NTM -CPT Code List" because they relate to otherwise non-covered services. This list is included as a special attachment in the Utah Medicaid Provider Manual for Hospital Services and also for Physician Services.

3. Non Covered Services for Laboratory and Radiology Services

a. Some laboratory and radiology procedures are non-covered and listed on the Medicaid Medical and Surgical Procedures list and "NTM - CPT Code List" because they relate to otherwise non-covered services.

2 - 5 Family Planning Services

Family planning services include disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. All services must be provided or authorized by a physician, certified nurse midwife, or nurse practitioner; must be provided in concert with Utah law; and must include prior written consent of a minor's parent or legal guardian. However, some services are specifically non-covered. Refer to Chapter 2 - 3, Physician Services, item 3, Non Covered Services for Physician Services, sub-item d, Excluded family planning services.

2 - 6 Hearing Services

Audiology services and hearing aides are not a covered benefit for Non-Traditional Medicaid.

2 - 7 Speech Therapy

Speech therapy services are not a covered benefit for Non-Traditional Medicaid.

2 - 8 Podiatry Services

Podiatry services are covered consistent with Traditional Medicaid services. Refer to the Utah Medicaid Provider Manual for Podiatry Services, SECTION 2 Podiatric Services.

2 - 9 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.

1. Covered Services for Vision Care

a. Examination and refraction.
b. Covered CPT Procedure Codes are: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99211, 99212, 99213, S0620, and S0621. The examination fee includes the refraction (glasses prescription)

2. Limitations for Vision Care

One exam, including the refraction, every 12 months. Medicaid pays the first $30 dollars for one annual examination and the client is responsible for all other additional charges.

3. Non Covered Services for Vision Care

Glasses are not a covered benefit.

2 - 10 Home Health Services

Home Health Services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, skilled nurse aides) in the client's home when the client's place of residence is the most appropriate and cost-effective setting consistent with the client's medical need. Home health care is to be rendered by a Medicare-certified Home Health Agency.

1. Covered Services for Home Health Services

Covered procedure codes are: T1001, S9123, T1999, S1030, T1021, T1003, T1031, S9124, T1020, S9122,T1022, S9131, S9128, G0154, S9485, S9480, T1002, G0081.(See Chapter 6, Home Health Procedure Codes in the Home Health Manual for detailed explanation.)

2. Non Covered Services for Home Health Services

a. Nursing or aide services requested for convenience of family, i.e., bathing, feeding, exercising, homemaking services, transfer services, giving medication, or acting as a companion or sitter, which do not require training, medical judgment technical skills of a nurse whether or not another person is available to perform such services, are not covered. This exclusion applies regardless of whether services were recommended by a provider. Non-covered services are:

(1) Private duty nursing.

(2) Custodial care.

(3) Respite care.

(4) Transportation, travel, escort services or food services.

2 - 11 Hospice Services

Service delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

1. Covered Services for Hospice

Covered Procedure Codes are: T2042, T2043, T2044, T2045, T2046.

2. Non Covered Services for Hospice

Nursing or aide services requested for convenience of family, i.e., bathing, feeding, exercising, homemaking services, transfer services, giving medication, or acting as a companion or sitter, which do not require training, medical judgment technical skills of a nurse whether or not another person is available to perform such services, are not covered. This exclusion applies regardless of whether services were recommended by a provider. Non-covered services are:

a. Private duty nursing.

b. Home health aide.

c. Custodial care.

d. Transportation, travel, escort services or food services.

2 - 12 Abortions and Sterilizations

Abortions and sterilizations are provided to the extent permitted by Federal and State Law and must meet the documentation requirements of 42 CFR 440 Subparts E and F. These procedures are identified on the Medicaid Medical and Surgical Procedures List, included as a special attachment in the Utah Medicaid Provider Manual for Physician Services, as requiring prior authorization and listing the specific criteria that must be met to approve a service consistent with 42 CFR 440 Subparts E and F. Related ICD.9.CM diagnosis codes are also listed.

Abortion services to unmarried minors must have written notification of the parent or legal guardian.

1. Covered Services for Abortions and Sterilizations

a. Physician
(1) Sterilization (male and female)

Covered CPT Procedure Codes are:

55250, 55450, 55530, 55535, 55540, 55550, 55600, 55605, 55650, 58563, 58600, 58605, 58611, 58615, 58661, 58670, 58671.

(2) Abortion - which meet federal and state law

Covered CPT Procedure Codes are: 59100, 59840, 59841, 59850, 59851, 59870, 59852.

b. Hospital

(1) Sterilization and Abortion

Covered ICD-9-CM procedures are identified on the Medicaid Medical and Surgical Procedures List, as requiring prior authorization and listing the specific criteria that must be met to approve a service consistent with 42 CFR 440 Subparts E and F.

Related ICD.9.CM diagnosis codes are also listed.

2. Limitations for Abortions and Sterilizations

a. Covered ICD-9-CM procedures are identified on the Medicaid Medical and Surgical Procedures List, as requiring prior authorization and listing the specific criteria that must be met to approve a service consistent with 42 CFR 440 Subparts E and F.

b. Abortion services to unmarried minors must have written notification of the parent or legal guardian.

2 - 13 Organ Transplants

The following transplantations are covered for all enrollee's kidney, liver, cornea, bone marrow, stem cell, heart and lung unless amended under the provisions of this health plan contract.

1. Covered Services for Organ Transplants

Covered CPT procedure codes are:

- Kidney 50360, 50365, 50380
- Liver 47135, 47136
- Cornea 65710 (does not require a prior authorization)
- Bone Marrow 38240, 38241
- Stem Cell 38240, 38241
- Lung 32851, 32852, 32853, 32854
- Heart 33945

2. Limitations for Organ Transplants

Codes covering these procedures are listed on the Medicaid Medical and Surgical Procedures List identified as requiring prior authorization and listing specific criteria that must be met to approve a service. This list is included as a special attachment in the Utah Medicaid Provider Manual for Physician Services.

2 - 14 Other Outside Medical Services

The health plan, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, surgical centers and birthing centers.

1. Emergency Center: These facilities, (InstaCare type) function as a physician office where ambulatory physician services are provided, usually on a schedule outside of usual physician office hours. Covered codes would be CPT codes appropriate for the office service. ICD.9.CM diagnosis codes may also be present to identify the reason for the service. There is no facility charge paid to such centers.

2. Surgical Center: These facilities, free standing, may provide outpatient surgery services appropriate for such a setting. Established criteria are applicable to services provided in this setting, i.e., prior authorization, exclusions, experimental or non-covered procedures, etc. Facility payment is based on the CPT procedure code listed.

3. Birthing Center: Free standing birthing facilities are limited in number. These facilities are usually staffed with certified registered nurse midwives who work with physicians to provide the service. (Specific codes are available if the CNMs provide the direct service as listed in the Certified Nurse Midwife provider manual.)

2 - 15 Transportation Services

Ambulance (ground and air) services for medical emergencies are covered.

1. Covered Services for Transportation Services

Covered procedure codes are A0422, A0425, A0429, A0430, A0431.

2. Non Covered Services for Transportation Services

Non-emergency transportation of any kind is not covered.

2 - 16 Preventive Services and Health Education

1. Covered Services for Preventive Services and Health Education

a. Preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management, are covered.

(1) These services are assumed under the general Evaluation and Management care provided to patients by the physician during medical visits. The services include counseling, anticipatory guidance, and/or risk factor reduction interventions. No special programs are covered.

(2) Special programs for Diabetes Self Management and Asthma are covered.

(3) Immunizations are available to Non-Traditional Medicaid clients in a medical office, but not at the pharmacy point of sale. For further information, see the Pharmacy and Physician Provider Manuals available at: www.health.utah.gov/medicaid.

2 - 17 Physical Therapy and Occupational Therapy

1. Covered services and authorized procedure codes for physical therapy and occupational therapy are:

   Physical Therapy: T1015
   Occupational Therapy: T1015 with GO modifier
   Rehabilitation Centers: T1015

2. Limitations for physical therapy and occupational therapy:

   a. Treatment and services must be provided by a licensed physical therapist or occupational therapist.
   b. No prior authorization is required.
   c. Maximum of 10 visits per calendar year in any combination of physical and occupational therapy.

2 - 18 Chiropractic Services

Chiropractic services are not a covered benefit for Non-Traditional Medicaid recipients.

2 - 19 Pharmacy Services *(Updated 7/1/13)*

The Medicaid Pharmacy Policy as set forth in the Utah Medicaid Provider Manual for Pharmacy Services for is hereby adopted for the Non-traditional Medicaid group of clients with the following changes. Coverage is more restrictive for units and time. Pharmacy services include prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription drug, service, or supply does not make it an eligible benefit, even though it is not specifically listed as an exclusion. The following pharmacy benefits and restrictions are incorporated into this program.

1. Drug Limitations and Benefits

a. The co-pay per client per prescription is $3.00 for a name brand drug, where a generic product is NOT available, or a generic drug.

b. There is no maximum co-pay, i.e., seven prescriptions will require a $21.00 co-pay which is due and payable prior to dispensing the prescription.

c. Prior approval and the criteria governing such are the same as the regular Medicaid program.

d. Generic products with an A B rating are mandated for dispensing.

e. When a generic product is available and the name brand is requested, the total payment must be made by the client. No physician DAW or prior authorization is available.

f. Non-Traditional Medicaid clients may receive brand name Tegretol, Dilantin, and Coumadin for the usual $3.00 co-pay due to the narrow therapeutic index of these drugs.

2. Drug Product Exclusions and Restrictions

a. The benefit for injectable medications is limited in scope. Antihemophilia Factor products (only available through University Hospital Home Infusion Services) and Insulin 10ml vials will be covered. The following injectables are available with prior authorization:

(1) Anti-emetics
(2) Heparin and low molecular weight heparin derivatives
(3) Antibiotics and diluents
(4) Anti-TNF agents to treat arthritis and Crohn's Disease
(5) MS Biologics
(6) Hepatitis C Biologics
(7) Erythropoetins
(8) GCSF (granulocyte colony-stimulating factor)
(9) Epinephrine Emergency Kits
(10) Medroxyprogesterone Acetate 150mg when used for family planning
(11) Insulin Pens (vials remain covered without prior authorization)

Criteria for these prior authorizations can be found in the *Drug Criteria and Limits* attachment available online at www.health.utah.gov/medicaid/pharmacy.

b. No duplicate prescription will be paid for lost, stolen, destroyed, spilled or otherwise non-usable medication with some exceptions.

c. No compounded prescriptions covered.

d. No lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner "uniqueness" will be covered, except where the specific medication is unavailable in any other form (Duragesic and Actiq -see chapter 2-19.3, Cumulative amounts). Lower-cost generic alternatives may be reviewed for exception to this policy.

e. Drugs are covered for labeled indications or Drug Utilization Review (DUR) Board approved indications only.

f. Specific classes of drugs are excluded by OBRA 91 statue.

(1) Cosmetic preparations
(2) Minerals
(3) Patches
(4) Vitamins, except prenatal
(5) Weight gain or loss

g. Drugs for Erectile Dysfunction are not covered.

h. No therapeutic duplication for long acting narcotics is allowed.

i. No therapeutic duplication for short acting narcotics is allowed.

Prior Approval Products:

Same as Medicaid Drug Criteria and Limits list, included as a special attachment in the Utah Medicaid Provider Manual for Pharmacy Services and also for Physician Services.

2 - 20 Mental Health Services

1. Covered Services for Mental Health Services
   Mental Health Services are covered under the Prepaid Mental Health Plan.

2. Limitations for Mental Health Services
   Services under the Non-traditional Medicaid Plan are limited to:
   a. Inpatient mental health care. 30-day maximum per year per enrollee for inpatient mental health care.
   b. Outpatient mental health services/visit. There is a maximum of 30 outpatient mental health services/visits per enrollee per year for outpatient mental health care. Targeted case management services for the chronically mentally ill also count toward the 30 outpatient mental health services/visit limit. Qualified providers are community mental health centers.
   c. Substituting. Substitution of outpatient mental health services/visits for inpatient days may be made if the enrollee requires more than 30 outpatient mental health services/visits per year, the enrollee would otherwise be hospitalized for treatment of the mental illness or condition, and in lieu of hospitalization, outpatient mental health services could be used to stabilize the enrollee. If the criteria for substitution are met, all outpatient mental health services, with the exception of day treatment (i.e., group skills development services), may be substituted at a rate of one outpatient mental health service/visit for one inpatient day. Day treatment may be substituted at a rate of two day treatment visits for each inpatient mental health day.

      Example: An enrollee has utilized the maximum outpatient mental health benefit by using ten outpatient day treatment visits and 20 other outpatient mental health services. However, without continued outpatient mental health treatment, the enrollee would require inpatient mental health care. Therefore, the enrollee utilizes another 20 day treatment visits and 15 other outpatient mental health services. The 20 outpatient day treatment visits are substituted for ten inpatient days and the 15 other outpatient mental health services are substituted for 15 inpatient days. The enrollee now has five inpatient mental health days available for the remainder of the year. The enrollee discontinues outpatient mental health treatment. An additional five outpatient mental health services could be used later in the year only if the enrollee again meets the substitution criteria. Without meeting these criteria, there are no remaining outpatient mental health benefits, only the five inpatient mental health days.

3. Non Covered Services for Mental Health Services

Mental Health and Substance Abuse Exclusions

The following exclusions apply to both mental health and substance abuse providers. Exclusions include:

a. Services for conditions without manifest psychiatric or substance abuse diagnoses (i.e., conditions that do not warrant a psychiatric or substance abuse diagnosis);

b. Hypnosis, occupational or recreational therapy;
c. Office calls in conjunction with medication management for repetitive therapeutic injections;
d. Mental health evaluations for legal purposes only (e.g., for custodial or visitation rights, etc.); and
e. Hospital charges for inpatient mental health stays while patient is on leave of absence.
f. In addition, targeted case management services provided by substance abuse providers are not a covered benefit.

2 - 21 Dental Services

Effective July 1, 2006, dental services are not covered, including emergency services.

2 - 22 Interpretive Services

Interpretive services are provided by entities under contract to Medicaid. Services include medical translation for people with limited English proficiency and interpretive services for the deaf.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill, nor be paid by, Medicaid. The provider who secured the service is responsible for payment.

2 - 23 Durable Medical Equipment

1. Non Covered Services for Durable Medical Equipment

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition. Durable medical equipment exclusions are:

a. Routine maintenance and care, cleaning solutions, upholstery repair, etc., of durable medical equipment (DME) or prosthetics.

b. Maintenance, warranty or service contracts.

c. Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.

d. Home physical therapy kits.

e Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.

f. Air filtration units, vaporizers, humidifiers.

g. Heating lamps or pads.

h. Charges for a continuous hypothermia machine, cold therapy, or ice packs.

i. Dialysis equipment.

j. Orthotics, arch supports, shoe inserts or wedges, etc.

k. Orthopedic or corrective shoes. (Attachment of a brace or crossbar is eligible.)

l. Hearing aids.

m. Adaptive devices used to assist with activities of daily living, vocational or life skills.

n. Communicative equipment or devices, systems, or components.

o. Computerized assistive devices, communicative boards, etc.,

p. Vitamins, minerals, food supplements, or homeopathic medicine.

q. Blood pressure monitors.

r. Wrist alarms for diabetics.

s. Enuresis alarm systems.

t. Spinal pelvic stabilizers.

u. orthopedic braces solely for sports activities.

v. More than one breast prosthesis for each affected breast following surgery for breast cancer, unless authorized as medically necessary.

w. More than one lens for each affected eye following corneal transplant surgery, unless authorized as medically necessary.

x. Computer systems or components.

y. Environmental control devices, i.e., light switches, telephones, etc.

z. Replacement of lost, damaged, or stolen DME or prosthetics.

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